HEALTH & HUMAN RESOURCES

Department of Medical Assistance Services

AT A GLANCE

Patrick Finnerty, Director

The Department of Medical Assistance Services (DMAS) is Virginia's Medicaid agency. The agency provides qualifying Virginians with access to a comprehensive system of high quality and cost effective health care services.

Staffing 453

Financials

Budget FY09: $5.85 billion

Budget FY10: $6.17 billion

46% General Fund

Trends

Health Care Providers: Steady

Claims: Steady

Customers: Increasing

Key Performance Areas

➡ Normal birth weights

⬆ Well child screenings

⬆Preventive dental care for children

⬆ Home & community care setting for the elderly

Productivity

⬇ Cost per claim

⬆ Medicaid recipients per DMAS employee

Administrative Measures

● Human Resource Management

● Procurement

● Financial Management

● Technology

● Performance Management

● Resource Stewardship

➡ Maintaining; ⬆ Improving; ⬇ Declining

Background & History

The Department of Medical Assistance Services (DMAS) administers a variety of state-funded and Medicaid-funded health care programs for qualifying Virginians. Medicaid, an entitlement program authorized under Title XIX of the Social Security Act, is financed by the state and federal governments and administered by the states.

SERVICES. DMAS provides reimbursements to healthcare providers, localities and state-run facilities for medical and related services provided to Virginians who qualify. Services include:

- Medical services provided to low-income children and to people covered by the Family Access to Medical Insurance Security Plan (FAMIS),
- Mental health and mental retardation services,
- Long-term care and assisted living services,
- Professional and institutional medical services,
- Charity care and uninsured medical catastrophe cases,
- State and local hospitalization programs, and
- Insurance premium payments for HIV-Positive individuals.

DMAS provides Medicaid to individuals through two general care delivery models: a model using contracted managed care organizations to coordinate care (started in 1996; used for 64% of total beneficiaries as of 12/07), and a fee-for-service model whereby service providers are reimbursed directly by DMAS (used for 36% of total beneficiaries as of 12/07).

CUSTOMER BASE. Approximately 87% of the department's customers are served through the Medicaid program. Persons eligible for Medicaid services primarily fall into particular categories such as low-income children, pregnant women, the elderly, persons with disabilities, and parents meeting specific income thresholds. Within federal guidelines, Virginia sets its own income and asset eligibility criteria for Medicaid. Over the past 10 years, the number of people enrolled in Virginia's Medicaid program has increased by 21% due primarily to increases in children enrolled due to significant outreach and education efforts regarding the need for childhood health coverage. Clients who are aged or disabled currently account for 30% of Virginia's Medicaid population and 70% of program expenditures.

Customers: Recipients of Benefits of the Following Programs as of Fiscal Year (FY) 2007	Customers Served Annually*	Projected Trend In # of Customers Served	Average Annual Cost Per Customer
Medicaid (adults) and FAMIS Plus (children)	873,934	Increase	TBD
FAMIS	63,580	Increase	TBD
Medicaid Expansion Program	57,658	Increase	TBD
Involuntary Mental Commitment Fund	8,600	Little or no change	TBD
State/Local Hospitalization Program	5,081	Decrease	TBD
Regular Assisted Living Program	1,278	Increase	TBD
HIV Premium Assistance Program	77	Increase	TBD
Uninsured Medical Catastrophe Fund	15	Increase	TBD

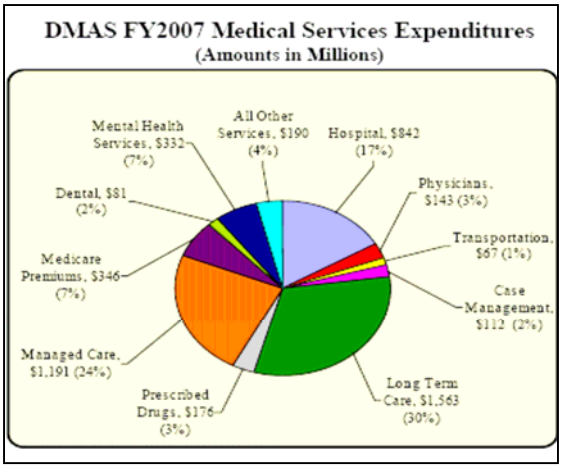
*The number of unduplicated enrollees or recipients for whom claims were paid during state fiscal year 2007.

FINANCES. DMAS-administered services comprise the largest single segment (12%) of the Commonwealth's budget. The DMAS budget is currently funded with approximately 46% state general funds, 49% nongeneral funds from the federal government, and 5% special (nongeneral) funds from the Family Access to Medical Insurance Security Plan Trust Fund, the Virginia Health Care Fund, and civil money penalties.

Fund Sources	FY 2009	FY 2010
General Fund (direct general taxes paid by citizens and businesses in Virginia such as income and sales tax)	$ 2,645,408,462	$ 2,807,740,460
Nongeneral Fund - Federal Government	$ 2,903,365,182	$ 3,064,090,114
Nongeneral Fund - Special	$ 292,089,053	$ 308,258,563
Total	$ 5,840,862,696	$ 6,180,089,137

Note: This is a sample of an agency annual report. Some of the information is fictional.

In fiscal year 2007, the agency's medical services expenditures totaled $4.97 billion, which represents an average annual increase rate of 11 percent since FY 2000. This increase has occurred despite several savings initiatives that were implemented to reduce costs. Long-term care, managed care and hospital expenses comprised the three largest categories of medical expenditures. Net administrative expenditures per total expenditures decreased 17% from 2.36% in FY 1999 to 1.94% in FY 2007. The agency's information technology budget is projected to be $16 million in FY 2009 and $25 million in FY 2010.



Population and economic change, such as health care cost inflation, as well as advances in health care delivery and program changes directed by federal and state decision makers, affect the agency's expenditure levels. Virginia's rate of growth in expenditures is comparable to other states, but the absolute level of spending remains low relative to other states. While Virginia enjoys higher than average per capita income (ranked 9th in 2006), the Commonwealth's Medicaid spending per recipient ranks 31st (2005) and spending per capita ranks near the lowest level nationally at 48th (2006).

Key Risk Factors

Four factors will have a significant impact on the department over the next XX years.

DEMOGRAPHIC TRENDS & UTILIZATION. The Department provided services to over 1,000,000 persons during fiscal year 2007. General population growth in Virginia and the growth of the aging population are key factors affecting the department's customer base. Since 1980, life expectancy at age 65 has increased 12% for males and 3% for females. Growth in this customer segment will result in an increase in the number of individuals receiving long-term care services and Medicare premium assistance through Virginia's Medicaid program and associated prescription drug programs. As more of these individuals begin to enroll, utilization rates will climb. Advances in medical technology are prolonging life and enabling better treatment of severe illnesses and disabilities. It is expected that the number of individuals who qualify for these new treatments will grow as the advances grow. Since 2002, the number of children served through the FAMIS and FAMIS Plus (Medicaid for Children) programs has grown over 40%.

NETWORK ACCESS. DMAS relies on its contracted health care providers to deliver services to customers. While there are some provider groups that often receive some level of increase in reimbursement (e.g., hospitals and nursing homes) and others that recently have received substantial increases in reimbursement (e.g., physicians providing obstetrics/gynecology services, dentists), some provider groups have received very modest increases over the past several years. Without increases in reimbursement for several provider groups, access to care will decline for DMAS patients as providers make business decisions to no longer participate in Medicaid or FAMIS. Even with recent increases, some providers are still paid well below the amounts paid by commercial insurers. Without an annual inflation factor or other type of routine adjustment, provider reimbursement will continue to be an impediment to providing needed services to customers.

The future direction of Virginia's Medicaid program will depend largely on decisions that are made in response to the call for Medicaid reform.

FEDERAL CHANGES. The federal government's Deficit Reduction Act of 2005 set forth a $30.9 billion reduction in Federal Medicaid funding from 2006-2015 based on numerous mandated changes to Medicaid programs across the country including: A) an upper payment limit for certain prescription drugs, B) documentation requirements for verify citizenship and identity for beneficiaries, and C) new asset transfer rules for long-term care eligibility. In addition, the federal government suggested several optional changes that states may implement. Two of the optional changes – increased cost sharing and benefit reductions – could have a significant impact on the delivery of medical assistance services. Unlike the current co-payment policies, states will have the option of making co-payments enforceable. This means that if a recipient does not pay, the provider will have the option to deny services. Virginia will need to weigh the advantages of charging higher co-payments and offering limited benefit packages against the disadvantages that would likely manifest in care access problems for Medicaid recipients and greater use of emergency rooms for routine care. The future direction of Virginia's Medicaid program will depend largely on decisions that are made in response to the call for Medicaid reform at the state and national level.

OPERATIONAL RISK FACTORS: COORDINATION OF SERVICE ACROSS STATE AGENCIES. DMAS works with 23 other state agencies, 10 of which are involved in health care related activities on DMAS's behalf. The Code of Virginia requires DMAS to contract with local departments of social services to determine which individuals are eligible to participate in the Medicaid program. DMAS paid the Department of Social Services (DSS) $52 million in FY 2006 for this service. In turn, DSS paid local governments to manage the eligibility determination process. Because the Federal Government would hold DMAS accountable for payments to ineligible individuals, the department is evaluating the effectiveness of controls surrounding the eligibility determination process to prevent costly mistakes or fraud. Other agencies involved in eligibility determination are the Department of Rehabilitative Services and Department for the Blind and Vision Impaired. In addition to DSS, the department coordinates various services (e.g., case management, provider training) through the Departments of Health, Aging, Education, Mental Health/Mental Retardation, Health Professions, and the Supreme Court of Virginia and MCV/UVA Hospitals.

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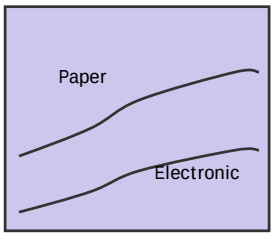
Performance Highlights

DMAS uses several performance indicators to monitor critical phases in its service cycle, productivity, costs and fraud. Significant indicators are listed below, including those designated as key measures, which are subject to review by the Governor's Office.

Key Performance Statistics	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Enrolled Providers (102 classes of providers)	50,346	48,753	54,753	41,988	TBD	TBD
Number of Claims Adjudicated	TBD	36,885,977	37,849,301	35,853,280	TBD	TBD
Child Immunization Rates (FAMIS) – 2 year-olds*	TBD	TBD	89.6%	90.2%	69%	TBD
Child Immunization Rates (FAMIS Plus) – 2 year-olds*	91%	92%	87%	86%	64%	TBD
Normal Birth Weights (Medicaid/FAMIS covered births)*	90%	89%	90%	89%	94.5%	TBD
Pediatric Dental Service Utilization Rate*	28.9%	25.1%	30.4%	35.9%	36.0%	TBD
Proportion of total Medicaid long term care expenditures for home and community bases services*	31.9%	33%	34.4%	36.2%	41.1%	TBD

*Governor's Key Measures

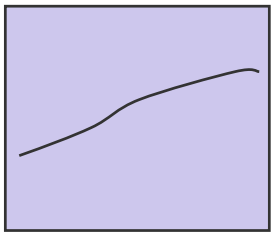
PRODUCTIVITY: Unit Claim Processing Cost (by submission method)



Background: Claims submission methods include paper, electronic and, in the future, web-based. Claims processing comprises around $4 million of the DMAS budget. Electronic processing of claims is significantly lower in cost than paper processing. Opportunities to reduce costs are great.

Trend Description: Increases **in c**laim costs have slowed in the past three years due to increases in the use of electronic submission and processing aids. Greater savings are expected over the next 3-5 years.

PRODUCTIVITY: # of Medicaid Recipients Per Employee



Background: Efforts at improving efficiency through the use of technology and improved work practices has enabled DMAS to process more claims and maintain quality, without increasing staff levels.

Trend Description: This figure has increased from 1,828 in FY 1998 to 2,511 in FY 2007, a 37% increase. Additional gains are expected over the next 3-5 years.

Management Discussion & Analysis

Virginia's Medicaid program is very large and complex and has many different components and activities. Priorities going forward reflect the complexity of the program. The top priority for DMAS is responding to state and national Medicaid reform issues as well as recommendations from the Medicaid Revitalization Committee, which was established as a result of House Bill 758 (2006) and signed by Governor Kaine on April 5, 2006, to set into motion self-examination of Virginia's Medicaid program. The Committee consisted of patient advocates, healthcare providers, and other stakeholders. During its tenure, the Committee examined alternative and innovative approaches to healthcare delivery under Medicaid with a focus on client-centered planning, individual budgeting, and self-directed quality assurance and improvement. The Committee also assessed options for changes to Medicaid that resulted from the Federal Deficit Reduction Act of 2005. Seven recommendations resulted. DMAS will focus on those recommendations along with other DMAS priorities over the next two – five years to ensure the department can continue to accomplish its mission in a cost-effective and high quality manner.

MEDICAID REVITALIZATION COMMITTEE RECOMMENDATIONS

1. Seek funding and approval to expand population-based disease management programs to target high cost and/or high prevalence disease states for which nationally accepted evidence-based care guidelines exist.
2. Seek funding and approval to provide access to enhanced benefit accounts, or a similar mechanism, in which recipients are rewarded for compliance with aspects of their care plan through financial incentives that can be used to purchase health care related goods and services not otherwise covered by the Medicaid program.
3. Require electonic funds transfer for payment of health care servies to all enrolled Medicaid providers.
4. Seek funding to implement a web-based claims submission system available free of charge to all health care providers for use in the submission of claims and for receipt of electronic remittance advices.
5. Continue working toward the goal of expanding managed care into new regions and across additional eligibility categories where feasible.
6. Study the potential impact of modifications to existing prorams for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals, including the impact of switching from mandatory to voluntary enrollment in these subsidy prorams.
7. Seek federal approval to expand, where feasible, "buy in" programs to allow expanded participation in the Medicaid and FAMIS programs.

DMAS PRIORITIES

1. SERVICES: Integrate acute and long-term care services; improve the effectiveness of waiver programs serving the elderly and persons with mental retardation or other disabilities; develop Program for All Inclusive Care for the Elderly (PACE) sites; monitor the dental program and make adjustments to improve access to care.
2. ENROLLMENT: Expand managed care enrollment; increase retention of eligible children in Medicaid and FAMIS.
3. OPERATIONS: Enhance the department's capabilities in preventing, identifying and eliminating fraud and abuse; increase the use of electronic systems to improve internal processes and administrative efficiences; improve SWAM constracting and purchasing; develop an Agency Risk Management program.

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